

REFERRAL  
TENNESSEE DEPARTMENT OF HEALTH

\_\_\_\_\_ County

Date \_\_\_\_\_

REFERRED TO: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PATIENT INFORMATION:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ FOLDER NO. \_\_\_\_\_

MEDICAID NO: \_\_\_\_\_

REASON FOR REFERRAL:

\_\_\_\_\_  
SIGNATURE AND TITLE

I hereby give the \_\_\_\_\_ County Health Department permission to  
release the appropriate information to \_\_\_\_\_ (Health Provider).

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian's Signature

\_\_\_\_\_  
(To be completed and returned to Health Department)

FINDINGS:

DIAGNOSIS, SUGGESTED TREATMENT AND FOLLOW-UP:

Date: \_\_\_\_\_

\_\_\_\_\_  
Health Provider's Signature and Title

I hereby give \_\_\_\_\_ (Health Provider) permission to release the  
appropriate information to \_\_\_\_\_ County Health Department.

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian's Signature

1st page - to be retained by Health Provider  
2nd page - to be returned to Health Department  
3rd page - for patient's chart in Health Department